STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00375125, IN00375260, IN00375643 and IN00376246. This visit resulted in an Extended Survey-Substandard Quality of Care- Immediate Jeopardy. Complaint IN00375125 - Unsubstantiated due to lack of evidence. Complaint IN00375260 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00375643 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F686, and F692. Complaint IN00376246 - Substantiated. Federal/State deficiency related to the allegations are cited at F689. Unrelated deficiency cited. Survey dates: March 25, 28, and 29, 2022 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 13 Medicaid: 48 Other: 42	F 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation.** **This provider alleges compliance as of 4/13/2022** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 5, 2022			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed accurately code falls on the Minimum Data Set for 2 of 3 residents reviewed for falls. (Resident E and F) Findings include: 1. The clinical record of Resident E was reviewed on 3/28/2022 at 11:57 p.m. The medical diagnoses included, but were not limited to, dementia and psychosis. A Quarterly Minimum Data Set, dated 12/6/2021, indicated Resident E needed assistance of one staff member for transferring and did not have any falls since the previous assessment. The previous assessment date was 9/16/2021. A nursing note, dated 11/1/2021, indicated that Resident E was found by the nurses' station, sitting on his bottom in the hallway with two abrasions. 2. The clinical record for Resident F was reviewed on 3/28/2022 at 1:32 p.m. The medical diagnoses included, but were not limited to,	F 0641	**F641 Accuracy of Assessments** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident E and F were identified during the time of observation. Resident E assessment modified with accurate coding of falls. Resident F assessment modified with accurate coding of falls. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All residents with falls have the potential to be affected. 2. MDS coordinator educated on accuracy of assessments related to falls. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. MDS coordinator will review falls 5 days a week in daily clinical	04/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dementia, Parkinson's, and overactive bladder. A Quarterly Minimum Data Set, dated 11/8/2021, indicated Resident F needed assistance of one staff member with transferring and did not have any falls since the previous assessment. The previous assessment date was 8/18/2021. A nursing note, dated 10/11/2021, indicated that Resident F fell to the buttocks at the side of the recliner in her with CNA assistance with transfer. An interview with the MDS Coordinator on 3/28/2022 at 2:15 p.m., indicated there was no policy for accuracy of Minimum Data Set assessment, that she follows the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual. The manual stated, "Determine the number of falls that occurred since admission/entry or reentry or prior assessment and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury."		meeting to ensure accurate coding of the MDS 2. MDS coordinator/designee will complete random chart audits for accurate coding of falls 2x/week for 4 weeks, weekly x4 weeks, then monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DHS or Designee will review any findings daily, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined.	
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the	F 0684	**F684 Quality of Care** What corrective action(s) will be	04/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to implement timely treatment of a deep vein thrombosis and to continually assess a change in resident's physical condition of leg redness, warmth, and swelling while awaiting diagnostic testing for suspected deep vein thrombosis (DVT) which resulted in 2 DVT in the lower extremity, one DVT in the upper left extremity, and one in the upper right extremity for 1 of 3 residents review for nursing assessments. (Resident D). Findings include: The clinical record for Resident D was reviewed on 3/25/2022 at 3:05 p.m. The medical diagnoses included, but were not limited to, end stage renal disease, repeated falls, and congestive heart failure. An Admission Minimum Data Set for Resident D, dated 1/30/2022, indicated that she was at risk for pressure areas, but did not have skin impairments. Resident D needed extensive assistance with eating, toileting, hygiene, and bed mobility. For transferring, walking, dressing, and locomotion, Resident D needed limited assistance of one staff member. A nursing note, dated 2/11/2022 at 2:16 p.m., indicated that Resident D was complaining of left lower extremity pain and had redness with edema. A new order for venous doppler to rule out DVT was ordered. A venous doppler is a special ultrasound used to assess the blood flow through blood vessels. A nursing note, dated 2/14/2022 at 8:28 a.m., was added to the chart on 3/28/2022 at 5:31 p.m. The note indicated that Resident D had not had		accomplished for those residents found to have been affected by the deficient practice? 1. Resident D was identified during the time of observation and no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All residents have the potential to be affected. 2. Nursing staff educated on change in condition guidelines including daily follow up assessments. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS/designee will review change in condition documentation 5x/week in daily clinical meeting. 2. DNS/designee will audit change in condition assessment documentation 2x week x4 weeks, weekly x4 weeks, then monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DHS or Designee will review any findings daily, with subsequent correction action and education for identified staff members.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her venous doppler to rule out DVT completed, that nurse practitioner (NP 6) was aware, and NP 6, "stated to make her aware once completed". A nursing note, dated 2/16/2022 at 11:40 a.m., indicated that Resident D still had not had her venous doppler completed and that the diagnostic test provider would reach out to the facility with an estimated time. A nursing note, dated 2/17/2022 at 1:13 p.m., indicated that doppler results of 2 DVT in the lower extremity, one DVT in the upper left extremity, and one in the upper right extremity. New order for Eliquis 5 milligrams (mg) twice a day for 7 days for DVT. A radiology report, dated 2/17/2022, indicated conclusion of acute DVT in the lower extremity, and it was recommended dedicate right leg venous doppler. Radiologist conclusion was reported by the diagnostic company on 2/17/2022 at 4:37 p.m. A physician order was added to the chart on 2/18/2022 at 8:07 p.m., for Eliquis 5 mg twice a day for 7 days. A physician order was added to the chart on 2/19/2022 at 7:21 a.m., for Eliquis 5 mg - give 10 mg twice a day for 7 days. A physician order was added to the chart on 2/19/2022 at 7:24 a.m., for Eliquis 5 mg twice a day for DVT to start on 2/27/2022. Per dosing guidance set forth on 7/2018 by Bristol-Myers Squibb, the manufacturer of Eliquis, treatment of DVT is indicated as Eliquis 10 mg twice a day for 7 days then to transition to		2. Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Eliquis 5 mg twice a day. A nursing note, dated 2/19/2022 at 5:39 p.m., indicated the family reported to the facility that Resident D had a history of DVTs. The medication administration for Resident D, indicated the first dose of Eliquis was given on 2/18/2022 at 9 p.m. at a dose of 5 mg. The medication administration record for Resident D, indicated the first dose of Eliquis 10 milligrams was given on 2/19/2022 at 9 a.m. No nursing note or evaluation present on chart to document the condition of, including pain, redness, or swelling, of Resident D's legs from discovery on 2/11/2022 until 2/17/2022 when multiple DVTs were diagnosed. An interview with DON on 3/29/2022 at 4:37 p.m., indicated that it would be an expectation that if a resident had redness, pain, and swelling, the nursing staff should be assessing and documenting their findings to monitor the condition. An interview with NP 6 on 3/29/2022 at 6:22 p.m., indicated that she kept all of her notes from the nursing facility and had no record of being contacted via phone or message in regard to Resident D on 2/14/2022. To her knowledge, her only interaction with Resident D was on 2/19/2022 regarding the status of wounds. NP 6 did not recall giving guidance to continue to wait for diagnostic testing to rule out a suspected DVT, and in her opinion, a delay of 6 days from order to completion, would be a "significant delay".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A policy entitled, "Change in Condition", was provided by the DON on 3/29/2022 at 3:05 p.m. The policy indicated that with any sudden or serious change in a resident's condition, the physician and family will be notified of the change in condition. This Federal tag relates to Complaint IN00375643.			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to conduct wound assessments completely and accurately on a facility acquired unstageable pressure area, resulting in the coccyx pressure area increasing in size and developing seropurulent drainage (Resident D) for 1 of 3 residents reviewed for pressure areas. Findings include: The clinical record for Resident D was reviewed	F 0686	**F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident D was identified during the time of observation and no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be	04/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on 3/25/2022 at 3:05 p.m. The medical diagnoses included, but were not limited to, end stage renal disease, repeated falls, and congestive heart failure. A Discharge Minimum Data Set for Resident D, dated 2/21/2022, indicated that no pressure wounds were present at the time of assessment. An Admission Minimum Data Set for Resident D, dated 1/30/2022, indicated that she was at risk for pressure areas, but did not have pressure wounds. Resident D needed extensive assistance with eating, toileting, hygiene, and bed mobility. For transferring, walking, dressing, and locomotion, Resident D needed limited assistance of one staff member. A physician order for Resident D, dated 1/30/2022, indicated to apply house barrier cream to buttocks, coccyx, and peri-area every shift. A pressure wound care plan, dated 2/9/2022, indicated that Resident D had a stage 2 pressure ulcer to the sacrum. Interventions were indicated as nursing staff to assess and document skin, notify MD of signs of infection, notify md of worsening or no improvements in wound, resident to utilize pressure reducing/redistributing mattress on the bed, and wound treatment as ordered. A physician order for Resident D, dated 2/9/2022, indicated to clean sacrum with normal saline, pat dry, apply medical honey to wound bed, and cover with border foam daily and as needed. A physician order for Resident D, dated		identified and what correction action(s) will be taken? 1. All residents with pressure wounds have the potential to be affected. 2. Nursing staff educated on wound assessment and treatment guidelines. 3. ADNS educated on wound assessment, treatment, and documentation. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS/designee will attend wound rounding 1x per month. 2. Wound assessment, treatment, and documentation will be reviewed weekly in Risk meeting. 3. DSN/designee will review all new admissions 5x/week for at risk residents to ensure appropriate wound prevention interventions in place. 4. DNS/designee will audit wound assessments and evaluations for accuracy and completion 2x/week for 4 weeks, weekly x4 weeks, then monthly x6 months. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DHS or Designee will review any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2/9/2022, indicated to utilize air mattress for pressure relived of unstageable sacral wound. A physician order for Resident D, dated 2/19/2022, indicated to apply Dakin's 0.5% solution to coccyx every shift with a wet to dry dressing for wound care. A physician order for Resident D, dated 1/30/2022, indicated to complete weekly nursing summary once a week. A nursing progress note, dated 2/9/2022, indicated "Received new orders today from NP [Nursing Practitioner]. Cleanse sacrum with normal saline, pat dry, medical honey to wound bed, cover with border foam change daily and PRN [as needed ...Air mattress for pressure relief of unstageable sacral wound." No associated wound assessment documented on 2/9/2022 to indicate size, characteristics, pain associated with, or if drainage was present in the sacral wound. A paper form, dated 2/10/2022, was provided by Director of Nursing on 3/28/2022 at 3:05 p.m. The form was entitled, "Wound Rounds". The document indicated Resident D had an acquired pressure wound to the coccyx measuring 1.2 x 1.5 x 0.1 centimeters (cm). No descriptions of the staging, wound bed, surrounding tissue, drainage, pain, or odor were present on the form. A paper form, dated 2/16/2022, was provided by the Director of Nursing on 3/28/2022 at 3:05 p.m. The form was entitled, "Wound Rounds". The document indicated that Resident D had an acquired pressure wound to the coccyx measuring 1.25 x 1.5 x 0.1 cm. No descriptions		findings daily, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the staging, wound bed, surrounding tissue, pain, or odor were present on the form. A nursing note, dated 2/19/2022, was added to the medical record on 3/28/2022. The note indicated that Resident D had a facility acquired pressure area to the right elbow measuring 0.4 x 0.7 x 0.1 cm with a scant amount of serosanguinous drainage and irregular borders. The medication and treatment administration record indicated on 2/20/2022 and 2/21/2022, Resident D received treatment of medihoney to coccyx daily, barrier cream to coccyx and buttocks, and Dakin's solution to sacrum. The medication and treatment administration record indicated blanks for weekly nursing summaries on 2/7/2022 and 2/21/2022. The nursing assessment for 2/14/2022 indicated it was not completed due to "drug refused". An interview with MDS on 3/28/2022 at 2:15 p.m., indicated that the Discharge Minimum Data Set did not include pressure areas because there were no documented pressure areas on the chart at the time of the discharge assessment being completed. An interview with LPN 4 on 3/28/2022 at 5:45 p.m., indicated she was the regular nurse that cared for Resident D. She indicated during her time here, she had gradual decline. The resident was only alert to self. An interview with LPN 4 on 3/29/2022 at 2:32 p.m., indicated that the wound order for the coccyx was changed on 2/19/2022 to Dakin's. She was unsure why it was changed, but Resident D did not utilize medihoney to the wound after			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	that date. She had discovered the wound to Resident D's elbow, but initially did not have time to document the assessment at the time of discovery, 2/19/2022, so she entered the assessment as a late entry on 3/28/2022. An interview with Assistant Director of Nursing, on 3/29/2022 at 12:20 p.m. She indicated she assumed the wound responsibilities on 2/8/2022. She remembered taking care of Resident D's wound. She indicated she used the paper form entitled, "Wound Rounds" as a personal reference. This is a form she developed for herself during training for her own tracking purposes. She indicated that just last week, she was educated on documented in the wound in the evaluations in the resident's record. She indicated she is not wound care certified, but she has resources and contract staff to reference for complicated wounds. When asked about Resident D's coccyx wound as being listed as unstageable in the original nursing note but having a measured depth of 0.1 cm on the Wound Round documents, she indicated she would have documented that differently now that she's had more education with wounds. Per her recollection, the 0.1 cm was the measured indention from wound edge to the top of the eschar located on the wound bed and not the true depth of the wound. Resident D discharged on 2/21/2022 directly to another extended care facility (FACILITY 2) per family request. Supplemental documentation from the FACILITY 2 indicated that Resident D admitted to the facility on 2/21/2022. An admission document, dated 2/21/2022 at 11:54 a.m., indicated a coccyx pressure ulcer with full thickness loss			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	through the dermis, down to subcutaneous tissue and muscle. The coccyx ulcer measured 7.5 x 10 cm with an unidentifiable depth due to slough, necrotic tissue, and eschar with odorous seropurulent drainage. The wound on the right elbow measured at 1.3 x 0.8 cm with an unmeasurable depth. A hospice agreement indicated that Resident D resided at FACILITY 2 and admitted to hospice services on 2/22/2022 for end-of-life care. A policy entitled, "Skin Management", was provided by the DON on 3/28/2022 at 3:05 p.m. The policy indicated that a head-to-toe assessment will be completed upon admission/readmission and no less than weekly, the licensed nursing is responsible for assessing any and all skin alternations as reported by the direct caregivers, all alternations in skin integrity will be documented in the medical record, and a plan of care will be initiated to include resident specific risk factors with appropriate interventions. This Federal tag relates to Complaint IN00375643. 3.1-40(a)(2)			
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure adequate supervision was in place when a cognitively impaired resident with dementia exited the facility on 3/17/22 without supervision through an unknown point of exit. The resident was picked up by a stranger with a medical transportation company and transported back to the facility. The resident exited the facility, again, on 3/21/22 through the window of an unoccupied room and found 1.6 miles away by facility staff and transported back to the facility. This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy began on 3/17/22 when a cognitively impaired resident with dementia exited the facility without facility knowledge. The Executive Director (ED) and Regional Vice President of Operations (RVPO) were notified of the Immediate Jeopardy on 3/28/22 at 5:17 p.m. The Immediate Jeopardy was removed on 3/29/22, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Findings include: The clinical record for Resident H was reviewed on 3/25/22 at 3:42 p.m. The diagnoses included but were not limited to, dementia, major depressive disorder, anxiety disorder, bipolar disorder, and schizoaffective disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 2/7/22, noted Resident H with	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident H was identified during the time of observation. Resident H continues to reside on the secured unit. Resident H had wander guard placed. All windows secured on unit. 2. Resident H received 1:1 observation and will remain on 15-minute checks indefinitely until able to relocate to another facility. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All residents that reside on secured unit with cognitive impairment have the potential to be affected. 2. Staff educated on elopement guidelines. 3. Maintenance secured all windows on unit. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. Maintenance/ designee will conduct elopement drill monthly. 2. MCF/designee updated all elopement assessments with	04/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	moderate cognitive impairment. Resident H required extensive assistance with one staff person for transfers, walking in room and locomotion on unit, limited assistance with one staff person for bed mobility, and impairment on one side of his lower extremity. A document titled "Social Service Progress Review for MDS Documentation", dated 3/3/22, indicated Resident H had severe cognitive impairment. A "Wandering/Elopement Risk Scale" assessment, dated 7/30/21, indicated Resident H was a "high risk for elopement". He exhibited the inability to follow instructions, the ability to ambulate, and a medical diagnosis of dementia/cognitive impairment. The interventions listed were for Resident H to remain on a locked unit. A "Wandering/Elopement Risk Scale" assessment, dated 1/21/22, indicated Resident H was "at risk to wander". He exhibited the ability to ambulate, had a history of wandering, and a medical diagnosis of dementia/cognitive impairment. The interventions listed were for Resident H to remain on a locked unit. The care plan, revised 1/21/22, indicated Resident H was an elopement risk due to exit seeking, impaired safety awareness. The goal for the resident was to not leave the facility unattended. Interventions included, but were not limited to, redirect resident when wandering or when exit seeking, place resident profile in elopement book, assess for unmet needs when wandering/exit seeking, Secure Care Wander Guard on his left ankle (added 3/24/22), and ask resident if he would like to go for a walk when		wander guards placed for residents identified. Elopement assessments will be updated quarterly and with any significant change in condition. 3. Maintenance/designee will complete daily audits of window mechanisms to ensure security. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DHS or Designee will review any findings daily, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the weather was nice around 3:00 p.m. (added 3/22/22). A Psychology Progress Note, dated 3/10/22, indicated Resident H was oriented to person with memory deficit noted. His comprehension, executive function, and insight noted mild impairment along with fair judgement. The document further indicated Resident H appeared confused and mildly disoriented. An anonymous interview was conducted during the survey from 3/25/22 to 3/29/22. They indicated Resident H had eloped from the facility on two occasions. The two occurred on 3/17/22 at 3/21/22. Resident H's progress notes were reviewed for March of 2022. Dated 3/17/22 at 7:03 p.m., indicated a "...Late Entry...Called residents sister made her aware of incident. She states it does not surprise her and that she is happy with care. Resident was assessed at 1555 no injury was noted at this time...." The progress note was created on 3/28/22 at 10:06 a.m. There was no further information regarding the incident on 3/17/22 in Resident H's clinical record. A progress note, dated 3/21/22, indicated contact was made with a family member but no indication of any incident occurring. No further indication of any incident occurring in Resident H's clinical record for 3/21/22. An interview with Qualified Medication Aide (QMA) 3, on 3/25/22 at 3:22 p.m., indicated she was working on the secured dementia care unit as the only care staff, instead of the usual two Certified Nursing Assistants (CNAs), and it was time to take the three residents out to smoke.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	There were three smoking residents and two non-smoking residents that went outside with me. This included Resident H. The smoke break was at approximately 3:09 p.m. and it usually lasted for 20 minutes or the duration of smoking two cigarettes. Around 5-10 minutes after the smoke break the staff noticed Resident H was missing. He returned later that evening because QMA 3 indicated she saw him at dinner. An interview with the Director of Marketing (DOM), on 3/25/22 at 3:10 p.m., indicated the facility received a call around 3:20 p.m. on 3/21/22 that an elderly gentleman was walking along the highway by an employee and it was believed to be a resident. She went to go check Resident H's room and could not locate him. She and Maintenance Director (MD) went to see if it was Resident H. It was Resident H walking along Highway US 44 in the grass and gravel area. He was alternating between a walk and a trot before stopping. Resident H was very confused and didn't know where he was going. This was the second time Resident H had left the building. Before this he was walking along the sidewalk on US 44, about a quarter of a mile. An interview with the MD, on 3/28/22 at 10:17 a.m., he indicated Resident H was found just past the gas station on the right side of US 44. He approximated it was a quarter of a mile. A transportation service noticed him walking and transported him back to the facility, on 3/17/22. The following day, 3/18/22, he was trying to get out of a window and was partially noted outside the window exposing his head and leg. On Monday, 3/21/22, someone from the therapy department believed they saw Resident H walking down US 44. He went with the DOM and Resident H was located by the sign that read 9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	miles to Liberty. It was located 1.6 miles from the facility. MD indicated he pulled up beside Resident H and he just kept walking. When we asked if he wanted a ride he responded "okay" and got into the vehicle. Resident H didn't seem to know who the DOM and myself were. There were already screws in the windows to allow for 4 to 6 inches of opening. Resident H put enough force to snap the screws off or loosen them to remove them himself. An interview conducted with the Executive Director (ED) on 3/25/22 at 4:00 p.m., indicated the incident on 3/17/22, Resident H's guardian was notified. He had a BIMS (Brief Interview for Mental Status) of 11 and it was his choice to go. It was a nice day and he wanted to go for a walk. He got down the road about one mile. The MD screwed down the windows on 3/17/22. On 3/21/22, he knocked out the screens and the window by removing the hex screws that prevented the window from opening completely. On 3/24/22, the extra brackets were placed on the windows for additional security. On 3/23/22 the Wander Guard was added and he had already cut it off and thrown it away. He loved being outside and with him having a BIMS of 11 and the acting with purpose "I didn't believe it was a reportable incident". We are looking into the situation to see if he's even appropriate for the secured unit. He was placed on a 72 hour one-on-one observation from 3/21/22 at 4:00 p.m. to 3/24/22 at 5:00 p.m. They had attempted to reach the guardian but no response. They were not 100% sure how he got out on 3/17/22. After the incident on 3/17/22, the facility staff just observed him closer, like every hour, over the weekend and that wasn't expected to be documented. It wasn't reported as an unusual occurrence because he was purposeful and his			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	BIMS was 11. An interview conducted with the Memory Care Facilitator, on 3/25/22 at 5:10 p.m., indicated she spoke with Resident H on 3/17/22 about letting the facility know when he would like to go out and they would be happy to go out with him. On 3/24/22, she asked Resident H why he didn't ask for supervision on 3/21/22 and he just "stared at me". She interpreted it as the resident was trying to remember the conversation she had with him on 3/17/22 but he couldn't recall. An interview with the ED and RVPO on 3/28/22 at 4:50 p.m., indicated they do not believe Resident H eloped from the facility but had an "unusual occurrence" to where he purposefully went for a walk due to the nice weather that occurred on that day. An interview conducted with Resident H, on 3/29/22 at 10:25 a.m., indicated he walked out "the door" to go for a walk a "couple of times" in the past week or so. He wanted to go to where his home was located in (name of city that was located approximately 16 miles away from the facility). He further indicated when he went for these "walks" he went to his home and walked back to the facility each time. A policy titled "Elopement", dated October 2019, was provided by the ED on 3/28/22 at 1:53 p.m. The policy indicated the following, ""Purpose...Care Team Members who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken...1. Residents identified to be at risk for elopement will be identified as follows...d. Care plans will be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	developed and individualized for residents who are at risk for elopement...5. Care Team Members will be educated to check the surrounding outside area when the door alarms to ensure no residents have exited the facility unattended...7. ISDH will be notified per the Unusual Occurrence Reporting Policy in regards to "Elopement....""" This Federal tag relates to Complaint IN00376246. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diet. Based on interview and record review, the facility failed to obtain a weight at the time of admission for 1 of 3 residents reviewed for weight management. (Resident D). Findings include: The clinical record for Resident D was reviewed on 3/25/2022 at 3:05 p.m. The medical diagnoses included, but were not limited to, end stage renal disease, repeated falls, and pericardial effusion. An Admission Minimum Data Set for Resident D, dated 2/6/2022, indicated admission dated of 1/30/2022, it was unknown, or did not, have weight loss and needed assistance of one staff member for eating tasks. Weights for Resident D were as follows: 2/1/2022 118.4 pounds (lbs.) 2/9/2022 118 lbs. 2/15/2022 117 lbs. A dietician review, dated 2/3/2022, indicated weight being 119 lbs. from hospital documentation, a recommendation of obtaining updated height and weight when able, and no new edema or skin issues noted. A policy, entitled, "Weight Assessment and Intervention", was provided by the DON on 3/28/2022 at 3:05 p.m. The policy indicated the nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter.	F 0692	**F692 Nutrition/Hydration Status Maintenance** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident D was identified during the time of observation and no longer resides at the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 1. All residents have the potential to be affected. 2. Nursing staff educated on Weight guidelines. 3. All current residents at facility have an accurate weight documented. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. DNS/designee will review new admission weight entry 5x/week in daily clinical meeting. 2. DNS/designee will review weight documentation and changes weekly in Risk meeting in collaboration with RD. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DHS or Designee will review any	04/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This Federal tag relates to Complaint IN00375643.		findings daily, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6 months or until substantial compliance has been determined.	
F 9999 Bldg. 00	(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. Based on interview and record review, the facility failed to report a cognitively impaired resident with a diagnosis of dementia exiting the facility on 2 occasions for 1 of 7 residents reviewed for elopement risk. (Resident H) Findings include:	F 9999	**F9999** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. Resident H was identified during the time of observation and continues to reside on the secured unit. How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken? 2. All residents have the potential to be affected. 3. RVPO will educate ED/DNS on reporting guidelines What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? 1. RNC/designee will review documentation of unusual events weekly x4 weeks then monthly x6 months. How the corrective action(s) will	04/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical record for Resident H was reviewed on 3/25/22 at 3:42 p.m. The diagnoses included but were not limited to, dementia, major depressive disorder, anxiety disorder, bipolar disorder, and schizoaffective disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 2/7/22, noted Resident H with moderate cognitive impairment. Resident H required extensive assistance with one staff person for transfers, walking in room and locomotion on unit, limited assistance with one staff person for bed mobility, and impairment on one side of his lower extremity. The care plan, revised 1/21/22, indicated Resident H was an elopement risk due to exit seeking, impaired safety awareness. The goal for the resident was to not leave the facility unattended. Interventions included, but were not limited to, redirect resident when wandering or when exit seeking, place resident profile in elopement book, assess for unmet needs when wandering/exit seeking, Secure Care Wander Guard on his left ankle (added 3/24/22), and ask resident if he would like to go for a walk when the weather is nice around 3:00 p.m. (added 3/22/22). An anonymous interview was conducted during the survey from 3/25/22 to 3/29/22. They indicated Resident H had eloped from the facility on two occasions. They occurred on 3/17/22 at 3/21/22. Resident H's progress notes were reviewed for March of 2022. The following was noted and dated for 3/17/22 at 7:03 p.m., "...Late Entry...Called residents sister made her aware of		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 1. For quality assurance, the DHS or Designee will review any findings daily, with subsequent correction action and education for identified staff members. 2. Findings will be reported at the QA meeting monthly x6months or until substantial compliance has been determined.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incident. She states it does not surprise her and that she is happy with care. Resident was assessed at 1555 no injury was noted at this time...." The progress note was created on 3/28/22 at 10:06 a.m. There was no further information regarding the incident on 3/17/22 in Resident H's clinical record. A progress note, dated 3/21/22, indicated contact was made with a family member but no indication of any incident occurring. No further indication of any incident occurring in Resident H's clinical record for 3/21/22. There was no reportable incident reported to the Indiana Department of Health Survey Report System about the incidents involving Resident H on 3/17/22 and 3/21/22. An interview with Qualified Medication Aide (QMA) 3, on 3/25/22 at 3:22 p.m., indicated she was working on the secured dementia care unit as the only care staff, instead of the usual two Certified Nursing Assistants (CNAs), and it was time to take the three residents out to smoke. There were three smoking residents and two non-smoking residents that went outside with her. This included Resident H. The smoke break was at approximately 3:09 p.m. and it usually lasted for 20 minutes or the duration of smoking two cigarettes. Around 5-10 minutes after the smoke break the staff noticed Resident H was missing. He returned later that evening because QMA 3 saw him at dinner. An interview conducted with the Director of Marketing (DOM), on 3/25/22 at 3:10 p.m., indicated the facility received a call around 3:20 p.m. on 3/21/22 that an elderly gentleman was walking along the highway by an employee and it			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was believed to be a resident. She went to go check Resident H's room and could not locate him. She and Maintenance Director (MD) went to see if it was Resident H. It was Resident H walking along Highway US 44 in the grass and gravel area. He was alternating between a walk and a trot before stopping. Resident H was very confused and didn't know where he was going. This was the second time Resident H had left the building. Before this he was walking along the sidewalk on US 44, about a quarter of a mile. An interview conducted with the MD, on 3/28/22 at 10:17 a.m., indicated Resident H was found just past the gas station on the right side of US 44. He approximated it was a quarter of a mile. A transportation service noticed him walking and transported him back to the facility, on 3/17/22. The following day, Friday, he was trying to get out of a window and was partially noted outside the window exposing his head and leg. On Monday, 3/21/22, someone from the therapy department believed they saw Resident H walking down US 44. He went with the DOM and Resident H was located by the sign that read 9 miles to Liberty. It was located 1.6 miles from the facility. An interview conducted with the Executive Director (ED) on 3/25/22 at 4:00 p.m., indicated the incident on 3/17/22 Resident H's sister, who is the guardian, was notified. He had a BIMS (Brief Interview for Mental Status) of 11 and it was his choice to go. It was a nice day and he wanted to go for a walk. He got down the road about one mile. He loved being outside and with him having a BIMS of 11 and the acting with purpose I didn't believe it was a reportable incident. We are looking into the situation to see if he's even appropriate for the secured unit. He			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was placed on a 72 hour one-on-one observation from 3/21/22 at 4:00 p.m. to 3/24/22 at 5:00 p.m. They had attempted to reach the guardian but no response. They were not 100% sure how he got out on 3/17/22. After the incident on 3/17/22, the facility staff just observed him closer, like every hour, over the weekly and that wasn't expected to be documented. It wasn't reported as an unusual occurrence because he was purposeful and his BIMS was 11. An interview conducted with the ED and RVPO conducted on 3/28/22 at 4:50 p.m., indicated they do not believe Resident H eloped from the facility but had an "unusual occurrence" to where he purposefully went for a walk due to the nice weather that occurred on that day. An interview conducted with Resident H, on 3/29/22 at 10:25 a.m., indicated he walked out "the door" to go for a walk a "couple of times" in the past week or so. He wanted to go to where his home was located in (name of city that was located approximately 16 miles away from the facility). He further indicated when he went for these "walks" he went to his home and walked back to the facility each time. A policy titled "Elopement", dated October 2019, was provided by the ED on 3/28/22 at 1:53 p.m. The policy indicated the following, ""Purpose...Care Team Members who have residents under their care are responsible for knowing the location of those residents, and in the case of a missing resident, ensuring appropriate action is taken...1. Residents identified to be at risk for elopement will be identified as follows...d. Care plans will be developed and individualized for residents who are at risk for elopement...5. Care Team			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Members will be educated to check the surrounding outside area when the door alarms to ensure no residents have exited the facility unattended...7. ISDH will be notified per the Unusual Occurrence Reporting Policy in regards to "Elopement....""			